

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038364</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Heritage Manor-Peru</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>22 ND & ROCK</u> <u>Peru</u> <u>61701</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>LaSalle</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(815) 223-4901</u> Fax # () _____		(Type or Print Name) <u>CRAIG L. ATER</u>	
IDPA ID Number: <u>370909086013</u>		(Title) <u>Senior Vice President -- Finance</u>	
Date of Initial License for Current Owners: <u>1965</u>		Paid Preparer (Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> GOVERNMENTAL		(Firm Name & Address) _____	
<input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Individual <input type="checkbox"/> State		(Telephone) <u>(309) 823-7135</u> Fax # () _____	
<input type="checkbox"/> Trust <input type="checkbox"/> Partnership <input type="checkbox"/> County		MAIL TO: OFFICE OF HEALTH FINANCE	
IRS Exemption Code _____ <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Other _____		ILLINOIS DEPARTMENT OF PUBLIC AID	
<input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		201 S. Grand Avenue East	
In the event there are further questions about this report, please contact:		Springfield, IL 62763-0001	
Name: <u>CRAIG L. ATER</u> Telephone Number: () _____		Phone # (217) 782-1630	

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Peru# 0038364 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>129</u>	Skilled (SNF)	<u>129</u>	<u>47,085</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>129</u>	TOTALS	<u>129</u>	<u>47,085</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>25,240</u>	<u>12,419</u>	<u>4,718</u>	<u>42,377</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,240</u>	<u>12,419</u>	<u>4,718</u>	<u>42,377</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.00%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1965

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 1965 NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided 4,718

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Peru

0038364

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	240,487	15,508		255,995		255,995	4,420	260,415		1
2	Food Purchase		162,782		162,782		162,782	(857)	161,925		2
3	Housekeeping	90,952	23,460		114,412		114,412		114,412		3
4	Laundry	61,628	16,555		78,183		78,183		78,183		4
5	Heat and Other Utilities			106,697	106,697		106,697	1,375	108,072		5
6	Maintenance	104,655	43,492	19,805	167,952		167,952	11,894	179,846		6
7	Other (specify):*										7
8	TOTAL General Services	497,722	261,797	126,502	886,021		886,021	16,832	902,853		8
	B. Health Care and Programs										
9	Medical Director			4,550	4,550		4,550		4,550		9
10	Nursing and Medical Records	1,642,525	144,989	9,161	1,796,675		1,796,675		1,796,675		10
10a	Therapy		211,019	189,916	400,935	(302,892)	98,043	81,022	179,065		10a
11	Activities	90,236	4,024		94,260		94,260		94,260		11
12	Social Services	29,715	141	4,739	34,595		34,595		34,595		12
13	Nurse Aide Training							2,457	2,457		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,762,476	360,173	208,366	2,331,015	(302,892)	2,028,123	83,479	2,111,602		16
	C. General Administration										
17	Administrative	79,636			79,636		79,636	114,230	193,866		17
18	Directors Fees							6,063	6,063		18
19	Professional Services			328,740	328,740		328,740	(317,325)	11,415		19
20	Dues, Fees, Subscriptions & Promotions			111,329	111,329	(70,628)	40,701	(18,075)	22,626		20
21	Clerical & General Office Expenses	132,941	11,683	21,047	165,671		165,671	240,270	405,941		21
22	Employee Benefits & Payroll Taxes			485,467	485,467		485,467	31,418	516,885		22
23	Inservice Training & Education			687	687		687	987	1,674		23
24	Travel and Seminar			10,211	10,211		10,211	(8,212)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,936	47,936		47,936	2,314	50,250		26
27	Other (specify):*			26,129	26,129		26,129	(24,365)	1,764		27
28	TOTAL General Administration	212,577	11,683	1,031,546	1,255,806	(70,628)	1,185,178	27,305	1,212,483		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,472,775	633,653	1,366,414	4,472,842	(373,520)	4,099,322	127,616	4,226,938		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number Heritage Manor-Peru

#0038364

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			141,111	141,111		141,111	18,028	159,139			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			114,038	114,038		114,038	244	114,282			32
33	Real Estate Taxes			33,453	33,453		33,453		33,453			33
34	Rent-Facility & Grounds							8,669	8,669			34
35	Rent-Equipment & Vehicles			6,150	6,150		6,150	14,415	20,565			35
36	Other (specify):*											36
37	TOTAL Ownership			294,752	294,752		294,752	41,356	336,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					302,892	302,892		302,892			39
40	Barber and Beauty Shops		1,202	16,244	17,446		17,446		17,446			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					70,628	70,628		70,628			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,202	16,244	17,446	373,520	390,966		390,966			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,472,775	634,855	1,677,410	4,785,040		4,785,040	168,972	4,954,012			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Peru

0038364

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,732)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,740	30		9
10	Interest and Other Investment Income	(39)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(619)	20		17
18	Fines and Penalties				18
19	Entertainment	(15,890)	24		19
20	Contributions	(365)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(347)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(22,157)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,266)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	229,238		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 229,238		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 168,972		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Peru

ID# 0038364

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$	0	0
2		0	0
3		0	0
4		0	0
5		(2,732)	35
6		0	34
7		0	
8		0	
9		6,740	30
10			32
11		0	
12		0	
13		(857)	2
14		0	32
15		0	33
16		0	24
17		(619)	20
18		0	
19			24
20		(365)	27
21		0	
22		(347)	19
23		0	
24		(24,000)	27
25		(22,157)	20
26		0	0
27		0	0
28		0	0
29		0	0
30		0	0
31		0	0
32			
33		0	33
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(44,337)	

Summary A

12/31/2002

[illegible]

Facility Name & ID Number Heritage Manor-Peru# 0038364

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization	75,292	GreenTree Therapy	100.00%	62,949	(12,343)	2
3	V							3
4	V	19 Adjustment for Related Organization	328,393	Heritage Enterprises, Inc.	100.00%		(328,393)	4
5	V							5
6	V	10a Adjustment for Related Organization	211,164	GreenTree Pharmacy	100.00%	304,529	93,365	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 614,849			\$ 367,478	\$ * (247,371)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Peru# 0038364Report Period Beginning: 1/01/2002Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 4,420	\$ 4,420
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				1,375	1,375
20	V	6 Maintenance				11,894	11,894
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				2,457	2,457
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				114,230	114,230
30	V	18 Directors Fees				6,063	6,063
31	V	19 Professional Services				11,415	11,415
32	V	20 Fees, Subscription, Promotions				4,701	4,701
33	V	21 Clerical & General Office Expenses				240,270	240,270
34	V	22 Employee Benefits & Payroll Taxes				31,418	31,418
35	V	23 Inservice Training & Education				987	987
36	V	24 Travel and Seminar				7,678	7,678
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				2,314	2,314
39	Total		\$			\$ 439,222	\$ * 439,222

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$	15
16	V	30 Depreciation				11,288	11,288	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				283	283	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				8,669	8,669	20
21	V	35 Rent-Equipment & Vehicles				17,147	17,147	21
22	V	36 Other				0		22
23	V	38 Medically Nec Transportation				0		23
24	V	39 Ancillary Service Centers				0		24
25	V	40 Barber and Beauty Shops				0		25
26	V	41 Coffee and Gift Shops				0		26
27	V	42 Other				0		27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 37,387	\$ * 37,387	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salary	\$ 21,350	line 17/18, col	1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.00	390,860	5	100.00	Director/Salary	21,000	line 17/18, col	2
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salary	18,432	line 17/18, col	3
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salary	19,899	line 17/18, col	4
5	Bob Dickson	Executive Vice Presid	Management	0.80	92,266	40	100.00	Salary	4,957	line 17, col 7	5
6	Cheryl Lowney	Executive Vice Presid	Management	0.30	186,564	50	100.00	Director/Salary	10,024	line 17/18, col	6
7	Steve Wannemacher	Executive Vice Presid	Management	0.30	175,068	50	100.00	Director/Salary	9,406	line 17/18, col	7
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	7,532	line 17, col 7	8
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	7,693	line 17, col 7	9
10											10
11											11
12											12
13								TOTAL	\$ 120,293		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Peru# 0038364

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,401	24	\$ 82,266	\$ 82,266	129	\$ 4,420	1
2	2 Food Purchase	Beds	2,401	24	0	0	129	0	2
3	3 Housekeeping	Beds	2,401	24	0	0	129	0	3
4	4 Laundry	Beds	2,401	24	0	0	129	0	4
5	5 Heat & Other Utilities	Beds	2,401	24	25,593	0	129	1,375	5
6	6 Maintenance	Beds	2,401	24	221,381	58,785	129	11,894	6
7	7 Other	Beds	2,401	24	0	0	129	0	7
8	9 Medical Director	Beds	2,401	24	0	0	129	0	8
9	10 Nursing & Medical Records	Beds	2,401	24	0	0	129	0	9
10	11 Activities	Beds	2,401	24	0	0	129	0	10
11	12 Social Service	Beds	2,401	24	0	0	129	0	11
12	13 Nurse Aide Training	Beds	2,401	24	45,737	39,267	129	2,457	12
13	14 Program Transportation	Beds	2,401	24	0	0	129	0	13
14	15 Other	Beds	2,401	24	0	0	129	0	14
15	17 Administrative	Beds	2,401	24	2,126,096	2,126,096	129	114,230	15
16	18 Directors Fees	Beds	2,401	24	112,849	0	129	6,063	16
17	19 Professional Services	Beds	2,401	24	212,454	0	129	11,415	17
18	20 Fees, Subscription, Promotions	Beds	2,401	24	87,500	0	129	4,701	18
19	21 Clerical & General Office Expense	Beds	2,401	24	4,472,002	4,183,145	129	240,270	19
20	22 Employee Benefits & Payroll Tax	Beds	2,401	24	584,769	0	129	31,418	20
21	23 Inservice Training & Education	Beds	2,401	24	18,362	0	129	987	21
22	24 Travel and Seminar	Beds	2,401	24	142,902	0	129	7,678	22
23	25 Other Admin. Staff Transportation	Beds	2,401	24	0	0	129	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,401	24	43,070	0	129	2,314	24
25	TOTALS				\$ 8,174,981	\$ 6,489,559		\$ 439,222	25

Facility Name & ID Number Heritage Manor-Peru# 0038364

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,401	24	\$	\$	129	\$	1
2	30 Depreciation	Beds	2,401	24	210,090		129	11,288	2
3	31 Amortization of Pre-Op & Org	Beds	2,401	24			129		3
4	32 Interest	Beds	2,401	24	5,270		129	283	4
5	33 Real Estate Taxes	Beds	2,401	24			129		5
6	34 Rent-Facility & Grounds	Beds	2,401	24	161,349		129	8,669	6
7	35 Rent-Equipment & Vehicles	Beds	2,401	24	319,142		129	17,147	7
8	36 Other	Beds	2,401	24			129		8
9	38 Medically Nec Transportation	Beds	2,401	24			129		9
10	39 Ancillary Service Centers	Beds	2,401	24			129		10
11	40 Barber and Beauty Shops	Beds	2,401	24			129		11
12	41 Coffee and Gift Shops	Beds	2,401	24			129		12
13	42 Other	Beds	2,401	24			129		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 695,851	\$		\$ 37,387	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	LaSalle National Bank		XX	Mortgage	4,640 plus Inter	01/15/99	\$ 3,269,400	\$ 2,047,758	01/15/06	variable	\$ 83,621	1							
2	LaSalle Loan Amortization		XX	Mortgage							8,318	2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Central Office Allocation		xx	Working Capital							22,099	6							
7	Central Office Allocation		xx	Working Capital							283	7							
8												8							
9	TOTAL Facility Related						\$ 3,269,400	\$ 2,047,758				\$ 114,321	9						
	B. Non-Facility Related*																		
10	Interest Income										(39)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$				\$ (39)	14						
15	TOTALS (line 9+line14)						\$ 3,269,400	\$ 2,047,758				\$ 114,282	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Heritage Manor-Peru**# **0038364** Report Period Beginning: **1/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 37,533	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 34,627	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,906)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 36,359	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 33,453	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	10	
	2000	11	
	2001	12	
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Peru COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0038364

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309) 823-7135 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>1709312014</u>	<u>Nursing Home</u>	\$ <u>34,033.00</u>	\$ <u>34,033.00</u>
2.	<u>1709312013</u>	<u>Nursing Home</u>	\$ <u>595.00</u>	\$ <u>595.00</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>34,628.00</u></u>	\$ <u><u>34,628.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Heritage Manor-Peru

0038364

Report Period Beginning:

1/01/2002 Ending:

12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			\$ 40,500	1
2					2
3	TOTALS			\$ 40,500	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	59	1965		\$ 391,963	\$		\$	\$
5	38	1966		325,283				
6	13	1970		153,474				
7	19	1985		677,402				
8								
Improvement Type**								
9	1978 Improvements	1978						
10	1979 Improvements	1979		6,059				
11	1980 Improvements	1980		9,952				
12	1981 Improvements	1981		28,648				
13	1982 Improvements	1982		8,175				
14	1983 Improvements	1983		39,938				
15	1984 Improvements	1985		13,985				
16	1985 Improvements	1986		19,793				
17	1986 Improvements	1987		550				
18	1988 Improvements	1988		22,120				
19	1989 Improvements	1989		19,053				
20	1990 Improvements	1990		25,453				
21	1991 Improvements	1991		12,118				
22	1992 Improvements	1992		19,157				
23	1993 Improvements	1993		87,224				
24	1994 Improvements	1994		43,270				
25	1995 Improvements	1995		16,885				
26	WATER SOFTNER	1996		8,377				
27	AIR CONDITIONER	1996		4,550				
28	LANDSCAPING	1996		97				
29								
30								
31								
32								
33								
34	C/O Allocation						11,288	11,288
35	Book Depreciation				79,463		87,000	7,537
36								1,403,823

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Interior Rehab---	1997	\$ 292,864	\$		\$	\$	\$	37
38	Parking Lot Sealer	1997	3,100						38
39	Commercial Disposal	1997	877						39
40									40
41	Water Heater	1998	4,308						41
42	A/C Repair	1998	6,457						42
43	Heater Repair	1998	954						43
44	Laundry Room Remodel	1998	1,450						44
45	Interior Rehab	1998	7,466						45
46									46
47	GFI Outlets	1999	3,420						47
48	Water Meter	1999	1,854						48
49	Roof Replacements	1999	80,498						49
50									50
51	Water Main Break Repair	2000	5,272						51
52	Door Monitor System	2000	9,852						52
53	Patio Improvements	2000	1,310						53
54									54
55	Lennox Condenser	2001	4,527						55
56	Water Heater	2001	3,708						56
57	Sewer Repair	2001	932						57
58									58
59	Sewer Repair	2002	1,267						59
60	Water Heater	2002	4,340						60
61	Ceiling Tiles	2002	110						61
62	Seal Parking Lot	2002	3,100						62
63	Door Lock	2002	1,370						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,372,562	\$ 79,463		\$ 98,288	\$ 18,825	\$ 1,403,823	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,372,562	\$ 79,463		\$ 98,288	\$ 18,825	\$ 1,403,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,372,562	\$ 79,463		\$ 98,288	\$ 18,825	\$ 1,403,823	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 852,260	\$ 61,648	\$ 60,851	\$ (797)		\$ 749,713	71
72	Current Year Purchases	38,338						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 890,598	\$ 61,648	\$ 60,851	\$ (797)		\$ 749,713	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,303,660	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 141,111	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,139	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,028	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,153,536	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 20,565 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 50,161	\$		\$ 50,161	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			9,319			9,319	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			117,868	1,717		119,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				302,667		302,667	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				225			225	13
14	TOTAL			\$		\$ 177,573	\$ 304,384		\$ 481,957	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Heritage Manor-Peru

0038364

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 49,145	\$	1
2	Cash-Patient Deposits	10,820		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	981,352		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,529		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,476,415		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,532,261	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	2,178,576		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	864,787		16
17	Accumulated Depreciation (book methods)	(1,532,350)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Tax Asset</u>	25,647		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,586,660	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,118,921	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 124,071	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,820		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,681		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,274		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,359		32
33	Accrued Interest Payable	6,024		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Security Deposits</u>	17,800		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 449,029	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,047,758		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,047,758	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,496,787	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,622,134	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,118,921	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,107,656	1
2	Restatements (describe):		2
3	<u>Audit Adjustment</u>	(69,999)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,037,657	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	584,477	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 584,477	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,622,134	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Peru

0038364

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,395,231	1
2	Discounts and Allowances for all Levels	(846,112)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,549,119	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	419,864	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 419,864	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,733	11
12	Gift and Coffee Shop	(2,092)	12
13	Barber and Beauty Care	25,571	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	371,133	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	150	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 400,495	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	39	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,369,517	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	886,021	31
32	Health Care	2,331,015	32
33	General Administration	1,255,806	33
B. Capital Expense			
34	Ownership	294,752	34
C. Ancillary Expense			
35	Special Cost Centers	17,446	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Loss from Non-Nursing property		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,785,040	40
41	Income before Income Taxes (line 30 minus line 40)**	584,477	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 584,477	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Peru

0038364

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,792	2,080	\$ 42,013	\$ 20.20	1
2	Assistant Director of Nursing	1,904	2,080	38,663	18.59	2
3	Registered Nurses	11,154	12,247	222,603	18.18	3
4	Licensed Practical Nurses	24,468	26,710	414,971	15.54	4
5	Nurse Aides & Orderlies	78,865	84,699	818,922	9.67	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,276	6,808	105,353	15.47	8
9	Activity Director					9
10	Activity Assistants	8,880	9,268	90,236	9.74	10
11	Social Service Workers	2,611	3,225	29,715	9.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,431	29,470	240,487	8.16	15
16	Dishwashers					16
17	Maintenance Workers	9,064	10,054	104,655	10.41	17
18	Housekeepers	11,746	12,699	90,952	7.16	18
19	Laundry	7,225	7,755	61,628	7.95	19
20	Administrator	2,080	2,080	79,636	38.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,366	10,494	132,941	12.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,862	219,669	\$ 2,472,775 *	\$ 11.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		4,550		36
37	Medical Records Consultant		2,514		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,739		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,403		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 70,628
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 1,184
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

